

Prevention

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bulletin

West Nile Virus Likely to Hit Arizona Hard This Year

By Bob England, M.D., M.P.H.

This is likely to be our big year for West Nile Virus (WNV). As this arbovirus has spread across the country, in almost every state, the second year of the presence of the virus has been the worst. Last year in Arizona, we had only six locally-acquired human cases, but found lots of evidence that the virus had become well-established throughout most of the state. Surveillance efforts identified WNV activity in at least 12 of our 15 counties.

It may seem like we live in a desert without many mosquitoes. Truth is, we have plenty – more than enough to create a significant risk for WNV transmission in many areas around the state. Mosquito breeding habitats abound in suburban, riparian and agricultural areas, and Culex mosquitoes (WNV vectors) are abundant. Furthermore, our arbovirus transmission season is about six months long going from May through October. We typically have higher, more consistent levels of St. Louis Encephalitis (SLE) than many areas of the country that are more heavily laden with mosquitoes. SLE is the closest cousin to WNV.

There are dozens of different species of mosquitoes and hundreds of species of birds potentially involved in the ecology of WNV.



It behaves differently in different environments, so we can't make precise predictions for Arizona. However, based on its history elsewhere, we can expect anywhere from dozens to possibly hundreds of clinical human cases this year.

As in all years, we and our partners will conduct surveillance of dead birds, sentinel chickens, horses and mosquitoes. Last year for example, the State Health Laboratory tested over 68,000 mosquitoes. Weekly updates including maps will be posted on our website: www.westnileaz.com.

Public health officials throughout Arizona will monitor WNV risk through surveillance and attempt to reduce risk through local mosquito control and prevention education. Arizonans will be urged to dump mosquito-breeding water in their yards, and encouraged to use insect repellants and other safeguards. In spite of our efforts, we know we're going to get hit anyway. We need you to consider this possible diagnosis in your patients this summer.

Human cases are most likely to occur from mid-summer to-early fall (July through October). Once human cases are reported, media coverage

will increase. You may then hear from patients concerned by common symptoms, such as those with headaches, or even those worried simply because they had a recent mosquito bite. There may be lots of requests for testing. Commercial clinical labs offer testing, while our State Lab will test based on specific criteria. In general, we offer testing for:

- Any patient hospitalized with encephalitis
- Any adult hospitalized with aseptic meningitis
- Any inpatient or outpatient who has previously tested positive by a commercial lab (commercial tests vary and we will **not** consider a case confirmed until the State Lab confirms this).

The State Lab performs an IgM Capture ELISA for WNV and SLE. Testing can be performed on serum or CSF, although serum is preferred. To obtain testing, or anytime you have a suspect WNV case, please call your local health department. Details for submitting samples are available from your local health department. It is also vital that we keep track of possible cases as the season progresses, so please call.

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Continued on page 3

Arizona
Department of
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Smoke Free
Environments
in Arizona
Page 2

Carbon
Monoxide
Page 3

2003-04
Influenza Season
Page 4

Early Diagnosis
Key To Preventing
Skin Cancer
Page 5

Communicable
Disease
Summary
Page 6-7

FDA Issues
Public Health
Advisory
Page 8

Smoke-Free Environments Building Momentum in Arizona

By Will Humble, M.P.H.

More and more cities, towns and counties in Arizona are passing ordinances that ensure smoke-free environments. Statewide support for smoke-free environments is particularly strong.

In a poll conducted in December 2003 by the *Arizona Republic*, 42 percent of Arizonans supported a statewide ban on public indoor smoking compared to 36 percent polled in December 2002. Overall, 73 percent are in favor of "some sort of" smoking limitation, compared to 65 percent in 2002.

The tumblers are falling into place to ensure smoke-free environments statewide, in part because several municipalities have implemented a wide variety of limitations on public smoking. Bar and restaurant owners in cities with strict, anti-smoking ordinances claim to be losing business as patrons flee to more smoking-friendly cities. Some of these business owners are among those pushing for statewide smoke-free environments.

Tempe and Guadalupe have restrictions that have strict limitations on smoking in all public places, including bars and restaurants. Mesa allows smoking in bars and small bars that are part of restaurants when they have separate ventilation. Chandler recently implemented a smoking ordinance similar to the one in Mesa.

Peoria recently passed an ordinance that bans smoking in all new bars and restaurants, but allows smoking in existing bars if they are separated by a floor-to-ceiling barrier and are independently ventilated. Prescott voters passed a workplace ban in November; however, bars are exempt from enforcement until 2005.

Coconino County has implemented an ordinance that prohibits smoking in all indoor places of employment including restaurants; however, there is an exemption for stand-alone bars. The City of Tucson prohibits smoking in any public vehicle (including

taxicabs), enclosed structures such as lobbies, hallways, restrooms, shopping malls, stores, restaurants, theaters, lockers and conference rooms.

The public health justification for ensuring smoke-free environments is solid. Secondhand smoke contains several hundred recognized toxic substances, including numerous carcinogens. The U.S. Environmental Protection Agency has classified secondhand smoke as a known cause of cancer in humans. Employees of bars and restaurants are exposed to the greatest amount of secondhand smoke, creating an occupational health risk so great that it would not be tolerated if the source were anything except tobacco smoke.

Children exposed to secondhand tobacco smoke are at increased risk of lower respiratory tract infections such as pneumonia and bronchitis. Secondhand smoke also increases the number of episodes and severity of symptoms in thousands of asthmatic

children in Arizona. Children exposed to secondhand smoke are also more likely to have reduced lung function and symptoms of respiratory irritation like cough, excess phlegm, and sneezing. Secondhand smoke may also increase the risk for sudden infant death syndrome.

Clinicians play a unique role in health-related public policy debates – especially this one. If you would like to play your part, you can contact Arizonans Concerned About Smoking at 623.465.2227 or <http://members.aol.com/acasinc>.

Will Humble is the Chief of Epidemiology and Disease Control Services and can be reached at 602.364.3855 or whumble@hs.state.az.us



Arizona Municipalities with 100% Smoke-free Environments

Municipality	100% Smoke-free Workplaces	100% Smoke-free Restaurants	100% Smoke-free Bars
Chandler	X		
Coconino County	X	X	
Gilbert	X		
Goodyear	X		
Guadalupe	X	X	X
Nogales	X		
Prescott	X		
Santa Cruz County	X		
Surprise	X		
Tempe	X	X	X

CLINICAL SUSPICION

Diagnosis of WNV infection is based on a high index of clinical suspicion and specific laboratory tests.



- WNV, or other arboviral diseases such as SLE, should be strongly considered in persons who develop unexplained encephalitis or meningitis in summer or fall, particularly in those >50 years of age.
- The local presence of WNV enzootic activity or other human cases should further raise suspicion (follow your local activity this season at our website: www.westnileaz.com)
- Travel and exposure history is also important (although many do not recall a mosquito bite).
- Contact your local health department to report suspect cases and to inquire about State Lab testing.

CLINICAL FEATURES

Most WNV infections are mild and often subclinical.

- ~ 80% no symptoms.
- ~ 20% "West Nile Fever" – often described as "mononucleosis-like" but some patients may experience severe muscle weakness and/or severe headache.
- < 1% severe neurologic disease – encephalitis, meningitis and/or acute flaccid paralysis (usually polio-like).

TREATMENT

For a more complete description of signs, symptoms and laboratory findings, see: www.cdc.gov/ncidod/dvbid/westnile/clinical_guidance.htm. For information on clinical trials, see <http://clinicaltrials.gov> and search for West Nile.

Carbon Monoxide and Your Patients' Health

By Will Humble, M.P.H.

Until recently, carbon monoxide poisonings were thought to occur only in enclosed, poorly ventilated areas. However, open-air cases of carbon monoxide poisoning have recently been identified from exhaust from various kinds of watercraft such as houseboats, cabin cruisers, and ski boats. In addition, carbon monoxide (CO) poisonings have been identified in semi-enclosed spaces and even outdoors from gasoline-powered tools such as chain saws, high-pressure washers, concrete cutting saws, power trowels, floor buffers, welders, pumps, compressors, and generators.

Parallel studies in the area by the Arizona Department of Health Services and the National Institute of Occupational Safety and Health during the 2003 Memorial Day weekend found that persons recreating or working in and near the channel waters near the London Bridge in Lake Havasu City were exposed to excessive levels of CO from watercraft exhaust. The studies found that police officers and persons recreating in the area had significantly higher carboxyhemoglobin (COHb) levels in their blood at the end of the day. The levels of COHb in participants' blood late in the day pose a public health hazard. Eight carbon monoxide poisonings (two fatal) associated with close proximity to operating motorboats have been documented in the last 6 years in the same area.

Often, the people that use or are in close proximity to watercraft, gasoline powered power tools and other small gasoline-powered engines are not aware that the watercraft and tools can present a serious health hazard from CO. Because it is colorless, odorless, and nonirritating, CO can overcome exposed persons without warning. Often there is little time before they experience symptoms that inhibit their ability to seek safety.

The initial symptoms of carbon monoxide poisoning are subtle and may include loss of manual dexterity, impaired judgment, dizziness and drowsiness. When the source of the CO is a watercraft or power tool, the symptoms could be occurring in close proximity to water hazards (including propellers) and dangerous power tools. The combination of CO exposure and potentially dangerous equipment poses an additional health risk because of the increased risk of trauma or drowning.

First responders, paramedics, emergency department physicians and ED staff are likely to be the front line health care workers when persons are overexposed to CO. These health care workers should consider examining whether exposure to CO may be a contributing factor in trauma cases that involved patients that were in close proximity to watercraft or gasoline power tools.

There are a number of inexpensive commercially available monoxide breath analyzers that effectively measure the amount of CO in the exhaled breath of patients. The instruments accurately convert the exhaled CO levels to a COHb in blood. The instruments are small, easy to use and store, require little maintenance, and do not require CLIA Certification.

If you find patients that appear to have CO poisoning and you suspect that there may be an ongoing environmental exposure that is responsible, please call the Arizona Department of Health Services Office of Environmental Health at 602.364.3142.

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2003-04 Influenza Season Earlier, Stronger Than Past Years

by Karen Lewis, M.D.

Influenza came in with a bang this year. However, it peaked quickly and left early.

The most frequently isolated viruses in the United States were influenza A (H3N2); 87% of these were similar to the Fujian strain. Preliminary data indicate that the recent season was more severe than the previous three seasons but was within the range expected for a typical A (H3N2) season⁽¹⁾.

Arizona had several weeks with widespread influenza activity. Figure 1 compares influenza data in Arizona over the last 7 years. Although influenza came early this year, the season was shorter than normal.

There will be new recommendations for influenza vaccine next fall. Since children under 2 years old are at high risk for complications from influenza, ACIP has recommended that all children ages 6 months-23 months should receive influenza vaccine⁽²⁾. The intranasal influenza vaccine is only approved for health people between the ages of 5-49 years old; therefore, children under 2 years old will need the inactivated form.

Influenza vaccine is not approved for children under 6 months old, even though they are at the highest risk of complications from influenza. The way to protect infants is to make sure that all family members are also vaccinated. Therefore, the influenza vaccine is also recommended for *all family members where there are children less than 2 years old in the home*⁽³⁾.

CDC will be emphasizing the importance of all health care workers getting a yearly vaccination. Currently, only 38% of health care workers in the United States get a yearly influenza vaccine⁽⁴⁾. Unvaccinated health care workers are potential vectors who can and do spread influenza to their patients⁽⁵⁾. To protect the patients that they care for, *all health care workers should get an influenza vaccine every fall*.

Avian influenza continues to be a possible source of a new influenza

pandemic⁽⁶⁾. Human cases of avian influenza could develop not just by travel to H5N1 influenza A affected countries in southeast Asia, by also by exposure to local poultry outbreaks of avian influenza. This year avian influenza outbreaks in poultry have been reported from multiple locations in North America. None have been related to the H5N1 avian influenza A outbreaks in Asia. Most were due to strains of low pathogenicity and did not affect humans. However, Texas reported one outbreak of highly pathogenic avian influenza A in poultry, and two poultry workers in British Columbia had mild illnesses due to avian influenza A.⁽¹⁾

Health-care providers should consider avian influenza in the differential diagnosis of febrile respiratory illnesses. Testing of hospitalized patients for H5N1 avian influenza A infection is indicated when **both** of the following exist: 1) radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternative diagnosis has not been established and 2) a history of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza infections in poultry or humans⁽⁷⁾. Health care providers should also be alert for respiratory illness in persons with exposure to

infected poultry in the week before the onset of their illness⁽⁸⁾.

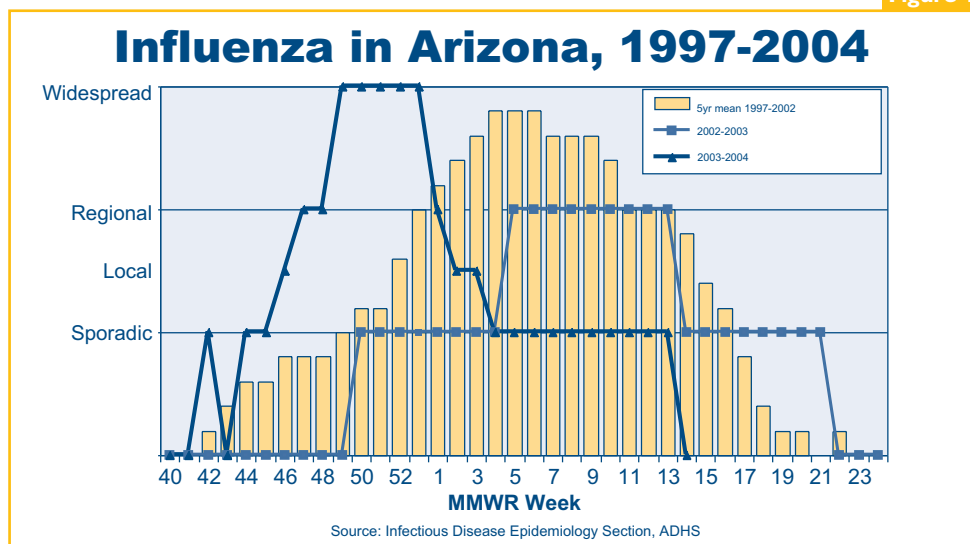
Persons suspected of having avian influenza should have a nasopharyngeal swab for influenza by direct antigen testing or PCR. Viral culture should not be done if avian influenza is suspected. If the result of antigen testing shows influenza A, or if there still is concern that there could be avian influenza, Arizona Department of Health Services would contact the CDC to arrange for avian influenza testing in a Biosafety Level 3+ Laboratory.

Karen Lewis, M.D., is an infectious disease specialist with the Office of Emergency Preparedness and Response and can be reached at 602.364.3574 or klewis@hs.state.az.us.

References:

1. CDC. Update: Influenza Activity—United States, 2003-04 Season. MMWR. 2004; 53 (13) 284-287.
2. Committee on Infectious Diseases. Policy Statement. Recommended Childhood and Adolescent Immunization Schedule—United States, January–June 2004 Pediatrics 2004; 113: 142-143
3. Prevention and Control of Influenza. MMWR. 2003; 52 (RR-8): 1-34.
4. Bridges CB, Kuehnert MJ, Hall CB. Transmission of Influenza: Implications for Control in Health Care Settings. CID 2003; 37: 1094-110.
5. Potter J, Stott DJ, Roberts MA, Elder AG, et al. Influenza Vaccination of Health Care Workers in Long-Term-Care Hospitals Reduces the Mortality of Elderly Patients. JID 1997; 175: 1-6.
6. Trampuz A, Prabhu RM, Smith TF, Baddour LM. Avian Influenza: A New Pandemic Threat? Mayo Clin Proc 2004; 79: 523-530.
7. CDC. Outbreaks of avian influenza A (H5N1) in Asia and interim recommendations for evaluation and reporting of suspected cases—United States, 2004. MMWR. 2004; (53) 5: 97-100
8. www.cdc.gov/fiu/pdf/han022404_recommendations.pdf Interim Recommendations for Persons with Possible Exposure to Avian Influenza During Outbreaks Among Poultry in the United States. Health Alert Network message February 24, 2004.

Figure 1



Early Diagnosis Key To Preventing Skin Cancer Deaths

By Amy Stoll, M.S., and Will Humble, M.P.H.

Skin cancer is the most common cancer in Arizona. Fortunately, approximately 95% of skin cancer cases are basal cell and squamous cell carcinomas, which while serious, are seldom fatal. Melanoma cancers represent the remaining 5% of skin cancers, but they account for about 77% of deaths due to skin cancer.

From 1995 to 2000, Arizona averaged 765 new cases of melanoma annually, with 120 average annual deaths. White, non-Hispanic men are at highest risk for melanoma in Arizona, with mortality rates that are more than double the rate for white, non-Hispanic women, and three times higher than Hispanic men. (See Fig. 1) Five-year survival from melanoma is about 97% if detected in the local stage. The survival rate drops sharply to 60% if detected in the regional stage. Five-year survival is only 14% when it is identified in the metastatic stage.

The key to reducing melanoma incidence in Arizona is increased public awareness of the importance of sun safety and changes in behavior. The key to reducing mortality is early detection and treatment.

Since 80% of a person's lifetime exposure to the sun occurs during childhood, protecting children and teaching them life-long sun protection behaviors is crucial to lowering skin cancer incidence rates. In order to begin the process of increasing awareness in children, the Arizona Department of Health Services began implementing the EPA's SunWise school program. The objective of the program is to teach children about sun safety and ultimately to improve the percentage of Arizona children who regularly use sun protection.

Our efforts to change the behavior of today's children will result in lowered incidence rates in, say, the year 2050, so a long and sustained effort will be necessary to reap these rewards. However, reducing mortality can be achieved in the short-run.

White, non-Hispanic men are at highest risk for melanoma in Arizona, with mortality rates that are more than double the rate for white, non-Hispanic women, and three times higher than Hispanic men.

As a clinician, you can play a part in encouraging early diagnosis. Your highest risk patients are white, non-Hispanic males over 50 that have a history of significant occupational or recreational sun exposure. Your next highest risk patients are white, non-Hispanic females over 50 with a history of excessive exposure. Persuading your patient to be vigilant about changes in skin color or texture and a thorough skin exam are the most effective tools that you have.

The Arizona Cancer Registry (ACR) receives approximately 15% of melanoma cases each year that cannot be classified as Arizona resident cases because of incomplete information from the pathology laboratories and physicians. If these additional cases were included as Arizona cases, it would increase the annual inci-

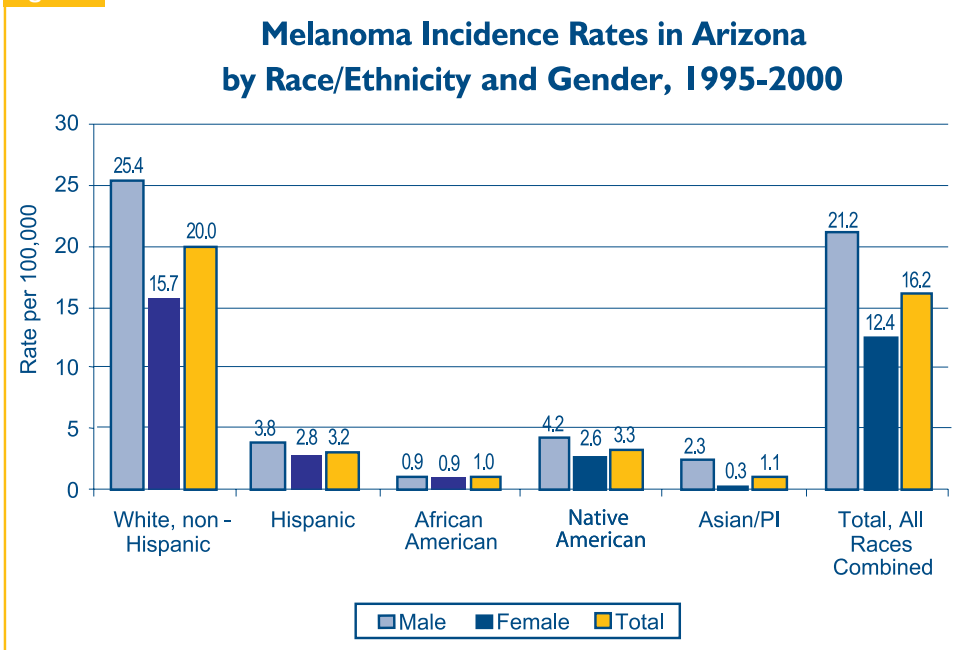
dence rate from 16/100,000 persons to 20/100,000 persons. In Arizona we want to ensure that what is reported is the most complete and accurate cancer incidence information. It is very important, therefore, that physicians who diagnose melanoma in their offices make an effort to report these cases to the registry. Also, the registry requests that incomplete reports mailed to physicians should be completed and returned to the registry.

The ACR has made it very simple to report cancer cases to the state. There are current reporting instructions and a simple, one-page reporting form available on the ACR website: <http://www.hs.state.az.us/phs/phstats/acr/reportingform.htm>

For free sun safety curriculum material, please visit our website at: <http://www.hs.state.az.us/phs/oeh/invsurv/index.htm> or contact SunWise Coordinator Sharon McKenna at: 602.364.3143 or 800.367.6412.

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Figure 1



Communicable Disease Summary

January 1, 2003 - December 31, 2003 – Provisional Data

Confirmed Cases Reported in 2003 by County of Residence

Yearly Totals

DISEASE	Apache	Cochise	Coconino	Gila	Graham	Greenlee	LaPaz	Maricopa	Mohave	Navajo	Pima	Pinal	Santa Cruz	Yavapai	Yuma	Unknown	2003	2002	2001
AIDS	3	4	6	-	-	-	1	279	4	3	81	19	3	3	8	-	414	547	522
Amebiasis	1	-	-	-	1	-	-	28	-	-	11	1	1	-	-	-	43	28	29
Botulism	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	1
Botulism, Infant	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	3	2
Brucellosis	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	6	6
Campylobacteriosis	57	10	66	5	8	-	2	464	5	14	147	12	13	16	2	29	850	734	635
Cholera	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	0	0
Chlamydia	372	150	419	97	78	10	31	7,765	151	424	2,408	319	62	183	332	-	12,801	14,930	14,357
Coccidioidomycosis	1	5	11	7	6	-	6	2,015	39	4	448	99	4	23	11	11	2,690	3,131	2,301
Colorado Tick Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Cryptosporidiosis	-	-	-	-	-	-	-	5	-	1	-	-	-	-	-	-	6	19	11
Dengue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	2	1
E. coli O157:H7	-	-	1	-	-	-	-	28	1	-	7	1	-	3	-	-	41	40	30
Ehrlichiosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	1
Encephalitis, SLE	-	-	-	-	-	-	-	5	-	-	-	-	-	-	-	-	5	1	1
Encephalitis, other	-	-	-	-	-	-	-	17	3	-	-	1	-	4	-	-	25	13	16
Giardiasis	2	1	7	2	3	-	1	168	16	3	36	5	2	3	5	2	256	268	267
Gonorrhea	41	26	26	9	9	2	1	2,683	26	98	469	109	5	19	54	-	3,577	3,785	3,923
Haemophilus influenzae	4	3	2	1	-	-	1	44	12	5	10	4	2	3	2	-	93	101	81
Hansen Disease	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	0	1
Hanta Pulmonary Syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	3	1
Hepatitis A	-	8	3	2	1	-	7	151	8	3	50	14	2	2	28	1	280	306	409
Hepatitis B	1	7	5	3	2	1	1	180	14	2	39	14	3	7	4	-	283	252	164
Hepatitis B (non-acute) ¹	8	14	15	4	3	1	2	718	26	14	139	40	4	13	25	44	1,070	1,125	1,502
Hepatitis C	1	-	-	-	2	-	-	2	-	1	-	-	-	1	-	-	7	6	9
Hepatitis C (non-acute) ²	46	236	143	81	204	13	19	5,892	368	205	1,213	733	19	309	290	231	10,002	10,261	6,813
Hepatitis D	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	2	5
Hepatitis E	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Hepatitis Non-A-B	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Herpes – genital	20	4	12	3	5	0	4	584	8	13	194	32	4	10	18	-	911	1,153	1,173
HIV infection	4	2	6	1	-	-	2	325	4	4	105	26	4	9	3	-	495	490	531
Legionellosis	-	-	-	-	-	-	-	12	2	-	2	-	-	2	1	2	21	15	21
Leptospirosis	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	0
Listeriosis	-	-	1	-	-	-	-	8	-	-	2	-	-	1	-	-	12	18	10
Lyme Disease	-	-	-	-	1	-	-	1	-	-	1	-	-	1	-	-	4	4	3
Malaria	-	1	-	-	-	-	-	17	-	-	4	1	1	1	-	1	26	17	19
Measles	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	0	1
Meningitis-Aseptic	-	32	7	1	-	-	-	1,140	31	10	196	42	11	15	31	-	1,516	273	206
Meningococcal	-	-	1	-	-	-	1	25	1	-	4	1	-	-	-	-	33	32	21

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Mumps	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	1	1	2
Pertussis	-	-	-	3	-	-	-	75	4	2	29	-	-	15	-	-	128	280	382
Plague	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Q Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Relapsing Fever, Tick	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	3
Reye Syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	1
Rocky Mountain Spotted Fever	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	1	0
Rubella	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Congenital Rubella Syndrome	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	0
Salmonellosis	30	10	31	9	11	1	1	380	19	19	151	36	14	33	24	13	782	809	732
Salmonella paratyphi A	-	-	1	-	-	-	-	2	-	-	-	-	-	-	-	-	3	3	2
Salmonella paratyphi B	-	-	-	-	-	-	-	4	-	-	-	-	-	-	-	-	4	11	3
Shigellosis	8	4	12	1	2	0	1	338	5	7	101	54	24	6	3	6	572	667	483
Streptococcal-Group A	6	4	12	1	0	1	0	149	14	7	48	12	0	5	0	1	260	314	187
Streptococcal-Group B ³	-	2	1	-	-	-	-	29	1	-	8	1	-	-	-	-	42	27	55
Streptococcus pneumoniae	27	17	39	3	5	1	3	424	30	16	96	38	1	5	4	10	719	788	783
Syphilis	3	-	2	-	-	-	-	132	2	-	40	2	4	1	-	-	186	201	180
Syphilis- Congenital	-	-	-	1	-	-	1	14	-	-	-	-	-	1	-	-	17	19	32
Tetanus	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0	0	1
Toxic Shock Syndrome	-	1	-	-	-	-	-	5	-	-	3	-	-	-	-	-	9	0	0
Tuberculosis	5	-	-	4	-	-	3	195	2	3	24	30	2	2	25	-	295	263	289
Tularemia	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	0	1
Typhoid Fever	-	-	-	-	-	-	-	1	-	-	1	-	-	-	-	-	2	0	2
Vibrio infection	-	1	2	-	2	1	1	8	-	-	4	-	-	-	-	-	19	9	6
Vancomycin Resistant Enterococci (VRE)	6	22	19	15	2	-	3	622	30	10	197	42	1	15	15	14	1,013	1,031	876
Yersiniosis	-	-	-	-	-	-	-	7	-	-	-	-	-	-	-	-	7	6	5

Source: ADHS/OIDS/IDES, 04/121/04

Notes: Only incident cases are reported. Streptococcus pneumoniae is lab reportable only. Haemophilus influenzae, Meningococcal, Streptococcal Group B and Streptococcus pneumoniae include invasive diseases only. Non-resident cases have been excluded. One case of Salmonella paratyphi C was reported in 1998.

1 The non-acute hepatitis B case count includes individuals with a positive HBsAg or HbeAg test alone and may include some acutely infected individuals. These counts reflect the year reported or tested and not the date infected. Case counts are not available before 1997.

2 The non-acute hepatitis C case count includes individuals with a positive screening test alone and may include falsely positive individuals. Known risk factors such as intravenous drug use increases the likelihood of these screening tests to be true positives. These counts reflect the year reported or tested and not the date infected. Case counts are not available before 1997.

3 Invasive disease in infants under 30 days of age.

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FDA Issues Public Health Advisory Regarding Antidepressant Medication

On March 22, the Food and Drug Administration (FDA) issued a Public Health Advisory for medical professionals to monitor for signs of suicidal ideation in individuals, especially children, who have recently started taking or have had a dosage change for antidepressant medication.

Although this raises significant concerns, it is important to consider that none of the conducted studies have shown that taking antidepressants causes suicide. There is no need for patients to panic, nor should these medications be abruptly discontinued. Evidence of increased irritability and agitation may reflect an adverse response to antidepressants and an increased risk of suicidal thoughts. These symptoms should quickly be reported to the prescribing physician.

Suicidal ideation is common among people with major depression.

Failing to appropriately treat depression and other related behavioral health problems also poses a significant risk of suicide.

Considerable research has proven that people suffering from depression can be significantly helped with antidepressant medication and/or psychotherapy. Patients should continue to take their prescribed medications as recommended and should consult with their physician if they notice any significant side effects or their condition shows signs of worsening. Failing to appropriately treat depression and other related behavioral health problems also poses a significant risk of suicide. It is important that parents of children with behavioral health prob-

lems make every effort to seek professional help.

ADHS recommends that all persons receiving treatment for depression or other behavioral health problems be routinely monitored for suicidal ideation. Since 75% of persons who complete suicide have visited a doctor within one month of committing suicide, it is important that medical professionals be vigilant in screening patients for suicide and other behavioral health problems during routine visits. Medical professionals should help patients and their families know the warning signs for suicide, medication side effects, and numbers to call in the event of an emergency.

For more information, contact Heather Brown, Suicide Prevention Coordinator, at 602.364.4854.